lated that the resistance may be borne on a related R-factor.

Since the continued occurrence of ampicillin resistant organisms appears likely, several therapeutic options have been suggested. In institutions with laboratories able to carry out suggested beta-lactamase assays and sophisticated susceptibility studies, as well as close clinical follow-up of patients, ampicillin may still be the treatment of choice until resistant organisms are proven to be a frequent problem. In institutions with limited laboratory facilities, therapy for serious infections due to suspected hemophilus organisms (that is, meningitis, sepsis, septic arthritis and the like) may be initiated with the combination of ampicillin (200 to 400 mg per kg of body weight per day, intravenously given in six doses) and chloramphenicol (50 to 100 mg per kg per day, intravenously given in four doses) or preferably chloramphenicol alone; therapy can be altered subsequently depending on the results of susceptibility tests. However, it must be cautioned that standard disc susceptibilities frequently are unreliable for H. influenzae. Therefore, proper treatment of these infections will depend primarily upon continuing surveillance of local susceptibility patterns as well as careful monitoring of the individual responses of patients to treatment.

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Imipramine (Tofranil®) in the Treatment of Enuresis

ENURESIS is considered abnormal in any child who consistently wets his bed after five years of age. Because there is no organic basis for the disorder in more than 90 percent of cases, genitourinary workup is held to a minimum. If in a child under 8 years old, there is no history of urinary tract infection, results are negative on urinalysis and concentration is possible to a specific gravity over 1.020, no further workup is undertaken. In children over 8 years intravenous pyelography and cystography are routinely carried out.

Until April 1973, administration of imipramine was not approved for children under 12 years of age. Since then it has been approved for use in children over 6 years. Administration of imipramine is one of the more useful treatments for enuresis in children without organic disease.

The suggested dose schedule is as follows: Children 6 to 12 years old may be started on 25 mg one hour before bedtime. If no improvement is noted, increase the dosage to 50 mg for four more weeks. If no improvement is noted, stop therapy. In patients over 12 years old the dosage may be increased to 75 or even 100 mg at bedtime. When improvement occurs treatment should be continued for three months and then gradually discontinued.

The exact mode of action of imipramine is unknown. Very few mild side effects occur on therapeutic doses. The major danger is accidental ingestion. Severe defects in cardiac conductivity resulting in irreversible heart block have resulted in a high mortality. The recently reported use of propanolol early in the course of accidental poisoning has resulted in a higher salvage rate.

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Anticholinergic Poisoning —New Antidote

THE INCIDENCE of poisoning by commonly used drugs and plants with anticholinergic properties is increasing. In spite of this increase, there is a general lack of knowledge of the specific antidote, physostigmine, for these poisons. Since there is dramatic reversal within minutes of the life-threatening symptoms due to this poisoning, it is essential that all clinicians treating these patients are aware of and skilled in the use of this antidote.

Drugs with anticholinergic properties consist of the tricyclic antidepressants (Elavil®, Triavil®); atropine; scopolamine; belladonna; the antihistamines (Benadryl®, chlorpheneramine); some over-the-counter sleep or calming medications (Sominex®, Compoz®, Cope®—containing methapyrilene); doxepin, and methyprylon (Noludar®).

Common plants with anticholinergic properties